



2016–2017 Student Injury and Sickness Insurance Plan

Designed Especially for the Students of



JOHNSON & WALES
UNIVERSITY



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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 1-800-767-0700 or visiting us at www.uhcsr.com/JWU.

Eligibility

All registered undergraduate day students (both domestic and international), all students enrolled in the Physician's Assistant program, Counseling graduate program, and all international graduate/doctoral students attending Johnson & Wales University, excluding full-time Johnson & Wales employees, taking credit hours are eligible and enrolled in this insurance Plan at registration unless proof of comparable coverage is furnished.

Home study, correspondence, and online courses do not fulfill the Eligibility requirements. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

Medical Leave of Absence: Johnson & Wales University allows eligible registered day and international graduate students to continue enrollment under the Johnson & Wales University Student Injury and Sickness Insurance Plan while on an approved medical leave of absence for a maximum of one term. Student must currently be enrolled in the University's Student Injury and Sickness Insurance Plan for at least one term. Student must have the medical leave of absence form signed by the Director of the Student Health Center or the Counseling Center or their designee. The Student must intend to return to the University and remain a degree-seeking candidate.

Effective and Termination Dates

The Master Policy becomes effective at 12:01 a.m., August 1, 2016. Coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., July 31, 2017. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier.

Coverage expires as follows:

Fall	08-01-16	to	11-28-16
Winter	11-29-16	to	03-06-17
Spring	03-07-17	to	07-31-17
Summer 1	06-01-17	to	06-30-17
Summer 2	07-01-17	to	07-31-17

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the student's responsibility to make timely premium payments to avoid a lapse in coverage.

Refunds of premiums are allowed only upon entry into the armed forces.

The Policy is a Non-Renewable One Year Term Policy.

Extension of Benefits after Termination

The coverage provided under the policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 12 months after the Termination Date.

The benefits payable during any period of extension of accrued liability will be subject to the policy regular benefits limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits).

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Pre-Admission Notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are:

UnitedHealthcare Options PPO.

The availability of specific providers is subject to change without notice. Insureds should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-767-0700 and/or by asking the provider when making an appointment for services.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Deductible must be satisfied before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Options PPO United Behavioral Health (UBH) facilities. Call 1-800-767-0700 for information about Preferred Hospitals. If a Preferred Provider is used within the network area, any additional services provided by an Out-of-Network provider will be paid at the Preferred Provider level of benefits.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Options PPO will be paid at the Coinsurance percentages specified in the Schedule of Benefits or up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Schedule of Medical Expense Benefits

METALLIC LEVEL – PLATINUM WITH ACTUARIAL VALUE OF 91.655%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible Preferred Providers	\$0
Deductible Out-of-Network	\$250 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Providers	100% except as noted below
Coinsurance Out-of-Network	80% except as noted below
Out-of-Pocket Maximum	\$6,850 (Per Insured Person, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Options PPO.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Any applicable Copays or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care See Benefits for Postpartum Care	Paid as any other Sickness	Paid as any other Sickness

Inpatient	Preferred Provider	Out-of-Network
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 7 working days prior to admission.	Paid under Hospital Miscellaneous Expenses	Paid under Hospital Miscellaneous Expenses

Outpatient	Preferred Provider	Out-of-Network
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance \$20 Copay per visit	Usual and Customary Charges
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance \$20 Copay per visit	Usual and Customary Charges
Medical Emergency Expenses Treatment must be rendered within 72 hours from the time of Injury or first onset of Sickness. The Copay/per visit Deductible will be waived if admitted to the Hospital.	Preferred Allowance \$50 Copay per visit	100% of Usual and Customary Charges \$50 Deductible per visit
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges
Prescription Drugs Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90 day supply	UnitedHealthcare Pharmacy (UHCP) \$10 Copay per prescription for Tier 1 \$25 Copay per prescription for Tier 2 \$45 Copay per prescription for Tier 3 up to a 31 day supply per prescription	No Benefits

Other	Preferred Provider	Out-of-Network
Ambulance Services The Insured Person's out of pocket expense shall not exceed \$50 maximum per trip for covered ground ambulance services.	Preferred Allowance	100% of Usual and Customary Charges
Durable Medical Equipment See also Benefits for Orthotic and Prosthetic Services for the Aged and Disabled	Preferred Allowance	Usual and Customary Charges
Consultant Physician Fees	Preferred Allowance \$20 Copay per visit	Usual and Customary Charges
Dental Treatment Benefits paid on Injury to Sound, Natural Teeth only.	Preferred Allowance	100% of Usual and Customary Charges
Mental Illness Treatment See Benefits for Treatment of Mental Illness and Substance Use Disorder	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See Benefits for Treatment of Mental Illness and Substance Use Disorder	Paid as any other Sickness	Paid as any other Sickness
Maternity See Benefits for Postpartum Care	Paid as any other Sickness	Paid as any other Sickness
Elective Abortion \$300 maximum per Policy Year	80% of Preferred Allowance	Usual and Customary Charges
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services No Deductible, Copays or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Mastectomy Treatment	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services See Benefits for Diabetes Treatment	Paid as any other Sickness	Paid as any other Sickness
Home Health Care See Benefits for Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	Preferred Allowance	Usual and Customary Charges
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials See also Benefits for New Cancer Therapies	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Medical Supplies Benefits are limited to a 31-day supply per purchase.	Preferred Allowance	Usual and Customary Charges
Ostomy Supplies	Preferred Allowance	Usual and Customary Charges
Travel Immunizations	Preferred Allowance	Usual and Customary Charges
Reconstructive Procedures	Paid as any other Sickness	Paid as any other Sickness

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug Product is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.uhcsr.com or call 1-855-828-7716 for the most up-to-date tier status.

\$10 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply.

\$25 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply.

\$45 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply.

Mail order Prescription Drugs are available at 2.5 times the retail Copay up to a 90 day supply.

Specialty Prescription Drugs – if you require Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drugs. If you choose not to obtain your Specialty Prescription Drug from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

Designated Pharmacies – if you require certain Prescription Drugs including, but not limited to, Specialty Prescription Drugs, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drugs. If you choose not to obtain these Prescription Drugs from a Designated Pharmacy, you will be responsible for the entire cost of the Prescription Drug.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present the card, you will need to pay for the prescription and then submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.uhcsr.com and log in to your online account or call 1-855-828-7716.

Additional Exclusions:

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven.
4. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Company determines do not meet the definition of a Covered Medical Expense.
5. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
6. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.

7. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
8. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.
9. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product.
10. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product.

Definitions:

Brand-name means a Prescription Drug: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that the Company identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a "brand name" by the manufacturer, pharmacy, or an Insured's Physician may not be classified as Brand-name by the Company.

Chemically Equivalent means when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy means a pharmacy that has entered into an agreement with the Company or with an organization contracting on the Company's behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Experimental or Investigational Services means medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, are determined to be any of the following:

- 1) Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- 2) Subject to review and approval by any institutional review board for the proposed use. Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.
- 3) The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- 1) Clinical trials for which benefits are specifically provided for in the policy.
- 2) If the Insured is not a participant in a qualifying clinical trial as specifically provided for in the policy, and has an Injury or Sickness that is likely to cause death within one year of the request for treatment the Company may, in its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

Unproven Services means services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- 1) Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- 2) Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If the Insured has a life-threatening Injury or Sickness (one that is likely to cause death within one year of the request for treatment) the Company may, in its discretion, consider an otherwise Unproven Service to be a Covered Medical Expense for that Injury or Sickness. Prior to such a consideration, the Company must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or Injury.

Generic means a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that the Company identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. The Insured should know that all products identified as a “generic” by the manufacturer, pharmacy or Insured’s Physician may not be classified as a Generic by the Company.

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

New Prescription Drug Product means a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Prescription Drug Cost means the rate the Company has agreed to pay the Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company’s periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.uhcsr.com or call Customer Service at 1-855-828-7716.

Prescription Drug List Management Committee means the committee that the Company designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Specialty Prescription Drug Product means Prescription Drug Products that are generally high cost, self-injectable biotechnology drugs used to treat patients with certain illnesses. Insured Persons may access a complete list of Specialty Prescription Drug Products through the Internet at www.uhcsr.com or call Customer Service at 1-855-828-7716.

Therapeutically Equivalent means when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

Usual and Customary Fee means the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Fee includes a dispensing fee and any applicable sales tax.

Insured Person's Right to Request an Exclusion Exception for UnitedHealthcare Pharmacy (UHCP) Prescription Drug Benefits

When a Prescription Drug Product is excluded from coverage, the Insured Person or the Insured's representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact the Company in writing or call 1-800-767-0700. The Company will notify the Insured Person of the Company's determination within 72 hours.

Urgent Requests

If the Insured Person's request requires immediate action and a delay could significantly increase the risk to the Insured Person's health, or the ability to regain maximum function, call the Company as soon as possible. The Company will provide a written or electronic determination within 24 hours.

External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request, the Insured Person may be entitled to request an external review. The Insured Person or the Insured Person's representative may request an external review by sending a written request to the Company at the address set out in the determination letter or by calling 1-800-767-0700. The Independent Review Organization (IRO) will notify the Insured Person of the determination within 72 hours.

Expedited External Review

If the Insured Person is not satisfied with the Company's determination of the exclusion exception request and it involves an urgent situation, the Insured Person or the Insured's representative may request an expedited external review by calling 1-800-767-0700 or by sending a written request to the address set out in the determination letter. The IRO will notify the Insured Person of the determination within 24 hours.

Medical Expense Benefits – Injury and Sickness

This section describes Covered Medical Expenses for which benefits are available in the Schedule of Benefits.

Benefits are payable for Covered Medical Expenses (see "Definitions") less any Deductible incurred by or for an Insured Person for loss due to Injury or Sickness subject to: a) the maximum amount for specific services as set forth in the Schedule of Benefits; and b) any Coinsurance or Copayment amounts set forth in the Schedule of Benefits or any benefit provision hereto. Read the "Definitions" section and the "Exclusions and Limitations" section carefully.

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for any matter described in "Exclusions and Limitations." If a benefit is designated, Covered Medical Expenses include:

Inpatient

1. **Room and Board Expense.**

Daily semi-private room rate when confined as an Inpatient and general nursing care provided and charged by the Hospital.

2. **Intensive Care.**

If provided in the Schedule of Benefits.

3. **Hospital Miscellaneous Expenses.**

When confined as an Inpatient or as a precondition for being confined as an Inpatient. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.

Benefits will be paid for services and supplies such as:

- The cost of the operating room.
- Laboratory tests.
- X-ray examinations.
- Anesthesia.
- Drugs (excluding take home drugs) or medicines.
- Therapeutic services.
- Supplies.

4. **Routine Newborn Care.**
While Hospital Confined and routine nursery care provided immediately after birth.

See Benefits for Postpartum Care.
5. **Surgery (Inpatient).**
Physician's fees for Inpatient surgery.
6. **Assistant Surgeon Fees.**
Assistant Surgeon Fees in connection with Inpatient surgery.
7. **Anesthetist Services.**
Professional services administered in connection with Inpatient surgery.
8. **Registered Nurse's Services.**
Registered Nurse's services which are all of the following:
 - Private duty nursing care only.
 - Received when confined as an Inpatient.
 - Ordered by a licensed Physician.
 - A Medical Necessity.
General nursing care provided by the Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility is not covered under this benefit.
9. **Physician's Visits (Inpatient).**
Non-surgical Physician services when confined as an Inpatient. Benefits do not apply when related to surgery.
10. **Pre-admission Testing.**
Benefits are limited to routine tests such as:
 - Complete blood count.
 - Urinalysis.
 - Chest X-rays.
If otherwise payable under the policy, major diagnostic procedures such as those listed below will be paid under the "Hospital Miscellaneous" benefit:
 - CT scans.
 - NMR's.
 - Blood chemistries.

Outpatient

11. **Surgery (Outpatient).**
Physician's fees for outpatient surgery.

When these services are performed in a Physician's office, benefits are payable under Physician's Visits (Outpatient).
12. **Day Surgery Miscellaneous (Outpatient).**
Facility charge and the charge for services and supplies in connection with outpatient day surgery, excluding non-scheduled surgery; and surgery performed in a Hospital emergency room; trauma center; Physician's office; or clinic.
13. **Assistant Surgeon Fees (Outpatient).**
Assistant Surgeon Fees in connection with outpatient surgery.
14. **Anesthetist Services (Outpatient).**
Professional services administered in connection with outpatient surgery.

15. **Physician's Visits (Outpatient).**

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits do not apply when related to Physiotherapy.

Benefits include the following services when performed in the Physician's office:

- Surgery.

Physician's Visits provided in the Insured's home are provided if the Insured has an Injury or Sickness which:

- Confines the Insured to his/her home.
- Requires special transportation.
- Requires the help of another person.

Physician's Visits for preventive care are provided as specified under Preventive Care Services.

16. **Physiotherapy (Outpatient).**

Includes but is not limited to the following rehabilitative services (including Habilitative Services):

- Physical therapy.
- Occupational therapy.
- Cardiac rehabilitation therapy.
- Manipulative treatment.
- Speech therapy. Other than as provided for Habilitative Services, speech therapy will be paid only for the treatment of speech, language, voice, communication and auditory processing when the disorder results from injury, trauma, stroke, surgery, cancer, or vocal nodules.

17. **Medical Emergency Expenses (Outpatient).**

Only in connection with a Medical Emergency as defined. Benefits will be paid for the facility charge for use of the emergency room and supplies.

All other Emergency Services received during the visit will be paid as specified in the Schedule of Benefits.

18. **Diagnostic X-ray Services (Outpatient).**

Diagnostic X-rays are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 70000 - 79999 inclusive. X-ray services for preventive care are provided as specified under Preventive Care Services.

19. **Radiation Therapy (Outpatient).**

See Schedule of Benefits.

20. **Laboratory Procedures (Outpatient).**

Laboratory Procedures are only those procedures identified in Physicians' Current Procedural Terminology (CPT) as codes 80000 - 89999 inclusive. Laboratory procedures for preventive care are provided as specified under Preventive Care Services.

21. **Tests and Procedures (Outpatient).**

Tests and procedures are those diagnostic services and medical procedures performed by a Physician but do not include:

- Physician's Visits.
- Physiotherapy.
- X-rays.
- Laboratory Procedures.

The following therapies will be paid under the Tests and Procedures (Outpatient) benefit:

- Inhalation therapy.
- Infusion therapy.
- Pulmonary therapy.
- Respiratory therapy.

Tests and Procedures for preventive care are provided as specified under Preventive Care Services.

22. **Injections (Outpatient).**
When administered in the Physician's office and charged on the Physician's statement. Immunizations for preventive care are provided as specified under Preventive Care Services.

23. **Chemotherapy (Outpatient).**
See Schedule of Benefits.

24. **Prescription Drugs (Outpatient).**
See Schedule of Benefits.

Other

25. **Ambulance Services.**
See Schedule of Benefits.

26. **Durable Medical Equipment.**
Durable Medical Equipment must be all of the following:

- Provided or prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Primarily and customarily used to serve a medical purpose.
- Can withstand repeated use.
- Generally is not useful to a person in the absence of Injury or Sickness.
- Not consumable or disposable except as needed for the effective use of covered durable medical equipment.

For the purposes of this benefit, the following are considered durable medical equipment:

- Braces that stabilize an injured body part and braces to treat curvature of the spine.
- External prosthetic devices that replace a limb or body part but does not include any device that is fully implanted into the body.

If more than one piece of equipment or device can meet the Insured's functional needs, benefits are available only for the equipment or device that meets the minimum specifications for the Insured's needs. Dental braces are not durable medical equipment and are not covered. Benefits for durable medical equipment are limited to the initial purchase or one replacement purchase per Policy Year. No benefits will be paid for rental charges in excess of purchase price.

See also Benefits for Orthotic and Prosthetic Services for the Aged and Disabled.

27. **Consultant Physician Fees.**
Services provided on an Inpatient or outpatient basis.

28. **Dental Treatment.**
Dental treatment when services are performed by a Physician and limited to the following:

- Injury to Sound, Natural Teeth.

Breaking a tooth while eating is not covered. Routine dental care and treatment to the gums are not covered. Pediatric dental benefits are provided in the Pediatric Dental Services endorsement attached.

29. **Mental Illness Treatment.**
See Benefits for Treatment of Mental Illness and Substance Use Disorder.

30. **Substance Use Disorder Treatment.**
See Benefits for Treatment of Mental Illness and Substance Use Disorder.

31. **Maternity.**
Same as any other Sickness. See Benefits for Postpartum Care.

32. **Complications of Pregnancy.**
Same as any other Sickness.

33. **Preventive Care Services.**

Medical services including routine physical exams, routine testing, preventive testing or treatment, and screening exams or testing in the absence of Injury or Sickness, that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

This is not a comprehensive list of Preventive Care Services, and certain diagnostic services provided in relation to preventive care may require cost share. Information regarding preventive services may be obtained from the following websites:

<http://www.uspreventiveservicestaskforce.org/uspstf/uspstabrecs.htm> and <http://www.hrsa.gov/womensguidelines/>.

34. **Reconstructive Breast Surgery Following Mastectomy.**

Same as any other Sickness and in connection with a covered mastectomy.

See Benefits for Mastectomy Treatment.

35. **Diabetes Services.**

Same as any other Sickness in connection with the treatment of diabetes.

See Benefits for Diabetes Treatment.

36. **Home Health Care.**

See Benefits for Home Health Care.

37. **Hospice Care.**

When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from a licensed hospice agency.

Hospice care includes:

- Physical, psychological, social, and spiritual care for the terminally ill Insured.
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care.

38. **Inpatient Rehabilitation Facility.**

Services received while confined as a full-time Inpatient in a licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related cause(s) as, a period of Hospital Confinement or Skilled Nursing Facility confinement.

39. **Skilled Nursing Facility.**

Services received while confined as an Inpatient in a Skilled Nursing Facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.
- Within 24 hours following a Hospital Confinement and for the same or related cause(s) as such Hospital Confinement.

40. **Urgent Care Center.**

Benefits are limited to:

- The facility or clinic fee billed by the Urgent Care Center.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

41. **Hospital Outpatient Facility or Clinic.**

Benefits are limited to:

- The facility or clinic fee billed by the Hospital.

All other services rendered during the visit will be paid as specified in the Schedule of Benefits.

42. **Approved Clinical Trials.**

Routine Patient Care Costs incurred during participation in an Approved Clinical Trial for the treatment of cancer or other Life-threatening Condition. The Insured Person must be clinically eligible for participation in the Approved Clinical Trial according to the trial protocol and either: 1) the referring Physician is a participating health care provider in the trial and has concluded that the Insured's participation would be appropriate; or 2) the Insured provides medical and scientific evidence information establishing that the Insured's participation would be appropriate.

"Routine patient care costs" means Covered Medical Expenses which are typically provided absent a clinical trial and not otherwise excluded under the policy. Routine patient care costs do not include:

- The experimental or investigational item, device or service, itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- Federally funded trials that meet required conditions.
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

See also Benefits for New Cancer Therapies.

43. **Transplantation Services.**

Same as any other Sickness for organ or tissue transplants when ordered by a Physician. Benefits are available when the transplant meets the definition of a Covered Medical Expense.

Donor costs that are directly related to organ removal are Covered Medical Expenses for which benefits are payable through the Insured organ recipient's coverage under this policy. Benefits payable for the donor will be secondary to any other insurance plan, service plan, self-funded group plan, or any government plan that does not require this policy to be primary.

No benefits are payable for transplants which are considered an Elective Surgery or Elective Treatment (as defined) and transplants involving permanent mechanical or animal organs.

Travel expenses are not covered. Health services connected with the removal of an organ or tissue from an Insured Person for purposes of a transplant to another person are not covered.

44. **Reconstructive Procedures.**

Reconstructive procedures when the primary purpose is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Condition. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Condition without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Insured Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Condition does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

45. **Medical Supplies.**

Medical supplies must meet all of the following criteria:

- Prescribed by a Physician. A written prescription must accompany the claim when submitted.
- Used for the treatment of a covered Injury or Sickness.

Benefits are limited to a 31-day supply per purchase.

46. **Ostomy Supplies.**

Benefits for ostomy supplies are limited to the following supplies:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

47. **Travel Immunizations.**

Travel immunizations only when rendered before travel. Immunizations are only covered to the extent that such immunizations are recommended for adults and children by the Centers for Disease Control and Prevention (CDC). The recommendations are subject to change by the CDC.

Mandated Benefits

BENEFITS FOR TREATMENT OF MENTAL ILLNESS AND SUBSTANCE USE DISORDER

Benefits will be paid the same as any other Sickness for the treatment of Mental Illness and Substance Use Disorder. Benefits will include Inpatient hospitalization, partial hospitalization provided in a Hospital or any other licensed facility, intensive outpatient services, Outpatient Services and Community Residential Care Services for Substance Use Disorder treatment. Benefits include medication assisted therapy, including methadone maintenance services, for the treatment of substance use disorders, opioid overdoses and chronic addiction.

“Outpatient services” means office visits that provide for the treatment of Mental Illness and Substance Abuse.

“Community residential care services” means those facilities as defined and licensed in accordance with Rhode Island Title 40.1, Chapter 24.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR MAMMOGRAPHY AND PAP SMEAR

Benefits will be paid the same as any other Sickness for mammograms and pap smears in accordance with the guidelines established by the American Cancer Society. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under this policy.

Benefits will be paid for two (2) screening mammograms per year when recommended by a Physician for Insured Persons who have been treated for breast cancer within the last five (5) years or are at high risk of developing breast cancer due to genetic predisposition (BRCA gene mutation or multiple first degree relatives) or high risk lesion on prior biopsy (lobular carcinoma in situ) or atypical ductal hyperplasia.

Mammography and Pap Smear covered by the Preventive Care Services benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Mammography and Pap Smear covered under this benefit will be paid the same as any other Sickness and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR MASTECTOMY TREATMENT

Benefits will be paid the same as any other Sickness for medically appropriate care as determined by the attending Physician in consultation with the Insured for an axillary node dissection or a Mastectomy for the treatment of breast cancer. Benefits will be paid for a minimum of 48 hours of inpatient care following a Mastectomy and a minimum of 24 hours after an axillary node dissection. If the Insured in consultation with the Physician chooses to be discharged earlier than the time period stated for the applicable procedure, benefits will be paid for a minimum of one home visit conducted by a Physician or Registered Nurse.

Benefits will be paid the same as any other Sickness for reconstructive surgery performed after a Mastectomy. Benefits will be paid for Prosthetic Devices and reconstruction to produce a symmetrical appearance. Benefits will be paid for prostheses and treatment of physical complications, including lymphedemas, at all stages of Mastectomy, in consultation with the attending Physician and the patient.

“Mastectomy” means the removal of all or part of the breast to treat breast cancer, tumor, or mass.

“Prosthetic devices” means and includes the provision of initial and subsequent prosthetic devices ordered by the Insured’s Physician.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PROSTATE AND COLORECTAL CANCER SCREENING

Benefits will be paid the same as any other Sickness for prostate and colorectal examinations and laboratory tests for cancer for any nonsymptomatic Insured in accordance with the current American Cancer Society guidelines.

Prostate and colorectal cancer screenings covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services benefit listed in the Schedule.

Prostate and colorectal cancer screenings covered under this benefit will be paid the same as any other Sickness and shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR POSTPARTUM CARE

Benefits will be paid the same as any other Sickness for the expense of postpartum care. Benefits will be provided for a minimum of forty-eight (48) hours of in-patient care following a vaginal delivery and a minimum of ninety-six (96) hours of in-patient care following a caesarean section for a mother and her newly born child including routine well-baby care. Any decision to shorten such minimum stay will be made by the attending Physician in consultation with the mother and will be made in accordance with the standards for guidelines for perinatal care published by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics. If the stay is less than the minimum, post-delivery care shall include home visits, parent education, assistance and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests, or any other tests or services consistent with the guidelines.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

BENEFITS FOR CONTRACEPTIVES

Benefits will be paid the same as any other outpatient Prescription Drug for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA). Benefits will not be provided for the Prescription Drug RU 486.

Contraceptive drugs and devices covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR THE TREATMENT OF INFERTILITY

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of Infertility for women. The Insured will be responsible for a Copayment of 20% of Covered Medical Expenses for those programs and/or procedures the sole purpose of which is the treatment of Infertility.

“Infertility” means the condition of an otherwise presumably healthy married individual who is unable to conceive or produce conception during a period of one (1) year.

Benefits shall be subject to all Deductibles, Copayments, Coinsurance, limitations and any other provisions of the Policy.

BENEFITS FOR DIABETES TREATMENT

Benefits will be paid the same as any other Sickness for the following equipment and supplies for the treatment of all types of diabetes, if recommended or prescribed by a Physician. Benefits shall include coverage for the following equipment and supplies for the treatment of diabetes: blood glucose monitors and blood glucose monitors for the legally blind, test-strips for glucose monitors and/or visual reading, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices, and oral agents for controlling blood sugar and therapeutic/molded shoes for the prevention of amputation.

Benefits will also be provided for the expense incurred for the education as to the proper self-management and treatment of the diabetic condition, including information on proper diet. Benefits shall be limited to visits Medically Necessary upon diagnosis of diabetes by a Physician or a significant change in the Insured Person's symptoms or conditions which necessitate changes in the Insured Person's self management; and upon determination of a Physician the re-education or refresher education is necessary. Diabetes self-management education shall be provided by a Physician.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR OFF-LABEL DRUG USE FOR CANCER TREATMENT

Benefits will be paid the same as any other Prescription Drug for any Drug prescribed to treat an Insured for cancer if the Drug is recognized for treatment of such indication in one of the Standard Reference Compendia or in Medical Literature. Benefits will not be paid for (a) any Drug not fully licensed or approved by the FDA, (b) the use of any Drug when the FDA has determined that use to be contraindicated, or (c) any experimental Drug not otherwise approved for any indication by the FDA. Benefits will include services associated with the administration of such Drugs.

“Standard reference compendia” means (a) the United States Pharmacopeia Drug Information; (b) the American Medical Association Drug Evaluations; or (c) the American Hospital Formulary Service Drug Information. “Medical literature” means published scientific studies published in at least two (2) articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

“Drug” means the primary anti-cancer or antineoplastic agent or agents.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

BENEFITS FOR NEW CANCER THERAPIES

Benefits will be paid the same as any other Sickness for new cancer therapies still under investigation when the following circumstances are present:

1. Treatment is being provided pursuant to a phase II, III or IV clinical trial which has been approved by the National Institutes of Health (NIH) in cooperation with the National Cancer Institute (NCI) Community clinical oncology programs; the Food and Drug Administration (FDA) in the form of an Investigational New Drug (IND) exemption; the Department of Veterans' Affairs; or a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants;
2. The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);
3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

4. The patients receiving the investigational treatment meet all protocol requirements;
5. There is no clearly superior, noninvestigational alternative to the protocol treatment; and
6. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as successful as the noninvestigational alternative.

Benefits will not be paid for new cancer therapy treatment under this provision for that portion of the treatment in connection with a Phase II clinical trial that is funded by a national agency or by commercial organizations.

Benefits shall be subject to all Deductibles, Copayment, Coinsurance, limitations or any other provisions of the policy.

BENEFITS FOR HUMAN LEUKOCYTE ANTIGEN OR HISTOCOMPATIBILITY LOCUS ANTIGEN TESTING

Benefits will be paid the same as any other Sickness for human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Benefits shall include the costs of testing for A, B or DR antigens. Benefits will be limited to one test per Insured per lifetime. The Insured must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

BENEFITS FOR HOME HEALTH CARE

Home health care services will be provided for the care and treatment of a covered Injury or Sickness provided that the following definition applies and the following limitations are observed. Home health care is defined as a Medically Necessary program to reduce the length of a Hospital stay or to delay or eliminate an otherwise Medically Necessary Hospital admission. The Home Health Care program must be formulated and supervised by the Insured Person's Physician, and must not exceed six home or Physician's office visits per month, three (3) nursing visits per week, and twenty (20) hours of home health aide visits per week.

Benefits include the following services as needed: physical or occupational therapy as a rehabilitative service, respiratory service, speech therapy, medical social work, nutrition counseling, Prescription Drugs and medication, medical and surgical supplies, such as dressings, bandages, and casts, minor equipment such as commodes and walkers, laboratory testing, x-rays and E.E.G. and E.K.G. evaluations.

Communicable diseases and Mental Illness are excluded from Home Health Care coverage.

Nutrition counseling covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Nutrition counseling covered under this benefit will be paid the same as any other Sickness and shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR TREATMENT OF LYME DISEASE

Benefits will be paid the same as any other Sickness for diagnostic testing and long-term antibiotic treatment recommended by a Physician for treatment of chronic Lyme disease. Benefits will not be denied solely because treatment may be characterized as unproven, experimental or investigational in nature.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR PEDIATRIC PREVENTIVE CARE

Benefits will be paid the same as any other Sickness exclusive of any Deductible provision in this policy for the cost of Pediatric Preventive Care Services provided for the ages specified below.

"Pediatric preventive care services" are those services recommended by the committee on practice and ambulatory medicine of the American Academy of Pediatrics when delivered, supervised, prescribed or recommended by a Physician and rendered to a child from birth through age nineteen (19). All such services must be in keeping with the prevailing medical standards.

Benefits are payable on a per visit basis to one health care provider per visit.

Pediatric Preventive Care Services covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Benefits shall be subject to all Copayment, Coinsurance, limitations, or any other provisions of the policy.

BENEFITS FOR SCREENING FOR LEAD POISONING

Benefits will be paid the same as any other Sickness for screening tests for lead poisoning for children under six (6) years of age, including but not limited to confirmatory blood lead testing.

Benefits are not payable where the child is eligible for benefits from the Department of Human Services.

Screening for lead poisoning covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Screening for lead poisoning covered under this benefit will be paid the same as any other Sickness and shall be subject to all Deductibles, Copayments, Coinsurance, limitations and any other provisions of the policy.

BENEFITS FOR HEARING AIDS

Benefits will be paid the same as any other Sickness for each individual Hearing Aid, per ear, every three (3) years for Insured Persons under 19 years of age.

"Hearing aid" means any nonexperimental, wearable instrument or device designed for the ear and offered for the purpose of aiding or compensating for impaired human hearing, but excluding batteries, cords, and other assistive listening devices, including, but not limited to FM systems.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR ORTHOTIC AND PROSTHETIC SERVICES FOR THE AGED AND DISABLED

Benefits will be paid for orthotic and prosthetic devices for the aged and disabled as specified below.

- Benefits will equal those benefits provided for under federal laws for health insurance for the aged and disabled pursuant to 42 U.S.C. sections 1395K, 1395I, 1395M and CFR 414.202, 414.210, 414.228, and 410.00 as applicable.
- Benefits will be limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's Physician.
- Benefits will be paid for repair and replacement costs, unless necessitated by misuse or loss.
- Benefits will be paid for treatment by any Orthotist or Prosthetist licensed to practice orthotics or prosthetics in Rhode Island.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR SCALP HAIR PROSTHESIS

Benefits will be paid the same as any other Sickness for a scalp hair prosthesis as a result of treatment of cancer or leukemia.

The Policy deductibles shall not apply to this benefit.

Benefits shall be subject to all other Copayments, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR TOBACCO CESSATION

Benefits will be paid the same as any other Sickness for Smoking Cessation Treatment.

Smoking Cessation Treatment includes the tobacco dependence treatments identified as effective in the most recent clinical practice guideline published by the United States Department of Health and Human Services for treating tobacco use and dependence.

Smoking Cessation Treatment may be redefined through regulation promulgated by the Health Insurance Commissioner, in accordance with the most current clinical practice guidelines sponsored by the United States Department of Health and Human Services or its component agencies.

If the policy does not provide Prescription Drug benefits, benefits will not be paid for Nicotine Replacement Therapy or any prescription drugs, but will provide outpatient counseling benefits for Smoking Cessation.

Nicotine Replacement Therapy includes but is not limited to nicotine gum, patches, lozenges, nasal spray and inhaler. Smoking Cessation Treatment covered by the Preventive Care Services Benefit and received from a Preferred Provider shall be covered with no cost share as referenced in the Preventive Care Services Benefit listed in the Schedule.

Smoking Cessation Treatment covered under this benefit will be paid the same as any other Sickness and shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR ENTERAL NUTRITION PRODUCTS

Benefits will be paid for the Covered Medical Expenses incurred for non-prescription enteral formulas for home use for which a Physician has issued a written order and which are a Medical Necessity for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, chronic intestinal pseudo-obstruction, and inherited disease of amino acids and organic acids.

Treatment of inherited disease of amino acids and organic acids shall include food products modified to be low protein.

Benefits shall be subject to all Deductible, Copayments, Coinsurance, limitations, or any other provisions of the Policy.

BENEFITS FOR AUTISM SPECTRUM DISORDERS

Benefits will be paid the same as any other Sickness for an Insured Person for the treatment of Autism Spectrum Disorders.

"Autism Spectrum Disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

"Applied Behavioral Analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvements in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Coverage shall include Applied Behavior Analysis, physical therapy, speech therapy and occupational therapy services for the treatment of Autism Spectrum Disorder.

Benefits shall be subject to all Deductible; Copayments; Coinsurance; limitations; or any other provisions of the Policy.

BENEFITS FOR ORALLY ADMINISTERED ANTICANCER MEDICATIONS

Benefits will be paid the same as any other Prescription Drug for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medication.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Coordination of Benefits Provision

Benefits will be coordinated with any other eligible medical, surgical or hospital plan or coverage so that combined payments under all programs will not exceed 100% of allowable expenses incurred for covered services and supplies.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of

Life	\$5,000
Two or More Members	\$5,000
One Member	\$2,500
Thumb or Index Finger	\$1,250

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Definitions

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

CONGENITAL CONDITION means a medical condition or physical anomaly arising from a defect existing at birth.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means reasonable charges which are: 1) not in excess of Usual and Customary Charges; 2) not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services and supplies which are a Medical Necessity; 6) made for services included in the Schedule of Benefits; and 7) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CUSTODIAL CARE means services that are any of the following:

1. Non-health related services, such as assistance in activities.
2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made. The deductible will apply as specified in the Schedule of Benefits.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means with respect to a Medical Emergency:

1. A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2. Such further medical examination and treatment to stabilize the patient to the extent they are within the capabilities of the staff and facilities available at the Hospital.

HABILITATIVE SERVICES means health care services that help a person keep, learn, or improve skills and functions for daily living when administered by a Physician pursuant to a treatment plan. Habilitative services include occupational therapy, physical therapy, speech therapy, and other services for people with disabilities.

Habilitative services do not include Elective Surgery or Elective Treatment or services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services.

A service that does not help the Insured person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis and major surgery on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

INJURY means bodily injury which is all of the following:

1. directly and independently caused by specific accidental contact with another body or object.
2. unrelated to any pathological, functional, or structural disorder.
3. a source of loss.
4. treated by a Physician within 30 days after the date of accident.
5. sustained while the Insured Person is covered under this policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility by reason of an Injury or Sickness for which benefits are payable under this policy.

INPATIENT REHABILITATION FACILITY means a long term acute inpatient rehabilitation center, a Hospital (or special unit of a Hospital designated as an inpatient rehabilitation facility) that provides rehabilitation health services on an Inpatient basis as authorized by law.

INSURED PERSON means the Named Insured. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1. Progressive care.
2. Sub-acute intensive care.
3. Intermediate care units.

4. Private monitored rooms.
5. Observation units.
6. Other facilities which do not meet the standards for intensive care.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1. Death.
2. Placement of the Insured's health in jeopardy.
3. Serious impairment of bodily functions.
4. Serious dysfunction of any body organ or part.
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MEDICAL NECESSITY/MEDICALLY NECESSARY means those health care services or supplies provided or prescribed by a Hospital or Physician which are all of the following:

1. Appropriate in terms of type, amount, frequency, level, setting and duration to the Insured's diagnosis or condition.
2. In accordance with generally accepted medical or scientific evidence.
3. Consistent with generally accepted practice parameters.
4. Not primarily for the convenience of the Insured, or the Insured's Physician.

The Medical Necessity of being confined as an Inpatient means that both:

1. The Insured requires acute care as a bed patient.
2. The Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Inpatient confinement.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the most recent revised publications or the most updated volume of either the *Diagnostic and Statistical Manual of the American Psychiatric Association* or the *International Classification of Disease Manual* published by the World Health Organization and that substantially limits the life activities of the person with the illness. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* or the *International Classification of Disease Manual* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year. Refer to the Schedule of Benefits for details on how the Out-of-Pocket Maximum applies.

PHYSICIAN means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means short-term outpatient rehabilitation therapies (including Habilitative Services) administered by a Physician.

POLICY YEAR means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

PRESCRIPTION DRUGS mean: 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and 4) injectable insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SICKNESS means sickness or disease of the Insured Person which causes loss while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

SKILLED NURSING FACILITY means a Hospital or nursing facility that is licensed and operated as required by law.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

TOTALLY DISABLED means a condition of a Named Insured which, because of Sickness or Injury, renders the Insured unable to actively attend classes.

URGENT CARE CENTER means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a reasonable charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions and Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

No benefits will be paid for services designated as "No Benefits" in the Schedule of Benefits or for procedures, equipment, services, supplies, or charges which the Company determines are not Medically Necessary or do not meet the Company's medical policy, clinical coverage guidelines, or benefit policy guidelines.

1. Learning disabilities.
This exclusion does not apply to Mental Illness and Substance Use Disorders.
2. Circumcision for non Medically Necessary cosmetic reasons.
3. Cosmetic procedures, except:
 - As specifically provided in the policy for Reconstructive Procedures.
 - To treat or correct Congenital Conditions of a Newborn Infant.
4. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.

5. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
6. Elective Surgery or Elective Treatment.
7. Health spa or similar facilities. Strengthening programs.
8. Hearing examinations. Hearing aids, except as specifically provided in the Benefits for Hearing Aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.

This exclusion does not apply to:

 - Hearing defects or hearing loss as a result of an infection or Injury.
9. Hirsutism. Alopecia.
10. Immunizations, except as specifically provided in the policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy.
11. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation.
12. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance.
13. Investigational services.
14. Lipectomy.
15. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the policy.
 - Immunization agents, except as specifically provided in the policy. Biological sera. Blood or blood products administered on an outpatient basis.
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in the Benefits for Off-Label Drug Use for Cancer Treatment.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Growth hormones.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
16. Reproductive/Infertility services including but not limited to the following:
 - Procreative counseling.
 - Genetic counseling and genetic testing.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Fertility tests.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except as specifically provided in the Benefits for Treatment of Infertility.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the policy.
 - Vasectomy.
 - Reversal of sterilization procedures.
17. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

This exclusion does not apply as follows:

 - When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
18. Services provided without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
19. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia, except for surgery to treat functional impairments. Temporomandibular joint dysfunction. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury.
20. Supplies, except as specifically provided in the policy.
21. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided in the policy. Gynecomastia, except when Medically Necessary.
22. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

23. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
24. Weight management. Weight reduction. Nutrition programs. Treatment for obesity (except surgery for morbid obesity). Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in the policy.

UnitedHealthcare Global: Global Emergency Services

If you are a member insured with this insurance plan, you are eligible for UnitedHealthcare Global Emergency Services. The requirements to receive these services are as follows:

International Students: you are eligible to receive UnitedHealthcare Global services worldwide, except in your home country.

Domestic Students: you are eligible for UnitedHealthcare Global services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by UnitedHealthcare Global; any services not arranged by UnitedHealthcare Global will not be considered for payment. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Emergency Response Center. UnitedHealthcare Global will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Key Services include:

- Transfer of Insurance Information to Medical Providers
- Monitoring of Treatment
- Transfer of Medical Records
- Medication, Vaccine
- Worldwide Medical and Dental Referrals
- Dispatch of Doctors/Specialists
- Emergency Medical Evacuation
- Facilitation of Hospital Admittance up to \$5,000.00 payment
- Transportation to Join a Hospitalized Participant
- Transportation After Stabilization
- Coordinate the replacement of Corrective Lenses and Medical Devices
- Emergency Travel Arrangements
- Hotel Arrangements for Convalescence
- Continuous Updates to Family and Home Physician
- Return of Dependent Children
- Replacement of Lost or Stolen Travel Documents
- Repatriation of Mortal Remains
- Worldwide Destination Intelligence Destination Profiles
- Legal Referral
- Transfer of Funds
- Message Transmittals
- Translation Services
- Security and Political Evacuation Services
- Natural Disaster Evacuation Services

Please visit www.uhcsr.com/UHCGlobal for the UnitedHealthcare Global brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States
(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at assistance@UHCGlobal.com.

When calling the UnitedHealthcare Global Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and UnitedHealthcare Global ID Number as listed on your Medical ID Card;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached.

UnitedHealthcare Global is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by UnitedHealthcare Global. Claims for reimbursement of services not provided by UnitedHealthcare Global will not be accepted. Please refer to the UnitedHealthcare Global information in **My Account** at www.uhcsr.com/MyAccount for additional information, including limitations and exclusions.

Online Access to Account Information

UnitedHealthcare **StudentResources** Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to **My Account** at www.uhcsr.com/myaccount. Insured students who don't already have an online account may simply select the "create **My Account Now**" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **StudentResources**' environmental commitment to reducing waste, we've adopted a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account now includes Message Center — a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In *Message Center*, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

ID Cards

One way we are becoming greener is to no longer automatically mail out **ID Cards**. Instead, we will send an email notification when the digital ID card is available to be downloaded from **My Account**. An Insured student may also use **My Account** to request delivery of a permanent ID card through the mail.

UHCSR Mobile App

The UHCSR Mobile App is available for download from Google Play or Apple's App Store. Features of the Mobile App include easy access to:

- ID Cards – view, save to your device, fax or email directly to your provider. Covered Dependents are also included.
- Provider Search – search for In-Network participating Healthcare or Mental Health providers, call the office or facility; view a map.
- Find My Claims – view claims received within the past 60 days for both the primary insured and covered dependents; includes Provider, date of service, status, claim amount and amount paid.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to **My Account** as described above and select **UnitedHealth Allies Plan** to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Claim Procedures for Injury and Sickness Benefits

In the event of Injury or Sickness, students should:

1. Report to the Student Health Service for treatment or referral, or when not in school, to their Physician or Hospital.

2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number (insured's insurance company ID number) and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3. Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Submit the above information to the Company by mail:

UnitedHealthcare **StudentResources**
P.O. Box 809025
Dallas, TX 75380-9025
800-767-0700

Pediatric Dental Services Benefits

Benefits are provided for Covered Dental Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits apply when the Insured Person chooses to obtain Covered Dental Services from a Network Dental Provider. Insured Persons generally are required to pay less to the Network Dental Provider than they would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will the Insured Person be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, the Insured must obtain all Covered Dental Services directly from or through a Network Dental Provider.

Insured Persons must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. Participation status can be verified by calling the Company and/or the provider. If necessary, the Company can provide assistance in referring the Insured Person to a Network Dental Provider.

The Company will make a Directory of Network Dental Providers available to the Insured Person. The Insured Person can also call Customer Service at 1-877-816-3596 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Insured's ID card.

Non-Network Benefits apply when Covered Dental Services are obtained from non-Network Dental Providers. Insured Persons generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on the Usual and Customary Fee for similarly situated Network Dental Providers for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the Usual and Customary Fee. As a result, an Insured Person may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the Usual and Customary Fee. In addition, when Covered Dental Services are obtained from non-Network Dental Providers, the Insured must file a claim with the Company to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

Benefits are eligible for Covered Dental Services if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a dental disease, does not mean that the procedure or treatment is a Covered Dental Service.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, the Insured Person may receive a pre-treatment estimate. To receive a pre-treatment estimate, the Insured Person or Dental Provider should send a notice to the Company, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide the Company with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

The Company will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the policy.

A pre-treatment estimate of benefits is not an agreement to pay for expenses. This procedure lets the Insured Person know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for all orthodontic services. The Insured Person should speak to the Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If the Insured Person does not obtain a pre-authorization, the Company has a right to deny the claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

- A. Necessary.
- B. Provided by or under the direction of a Dental Provider.
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure.
- D. Not excluded as described in Section 3: Pediatric Dental Services exclusions.

Dental Services Deductible

Benefits for pediatric Dental Services are not subject to the policy Deductible stated in the policy Schedule of Benefits. Instead, benefits for pediatric Dental Services are subject to a separate Dental Services Deductible. For any combination of Network and Non-Network Benefits, the Dental Services Deductible per Policy Year is \$500 per Insured Person.

Out-of-Pocket Maximum

Any amount the Insured Person pays in Coinsurance for pediatric Dental Services under this benefit applies to the Out-of-Pocket Maximum stated in the policy Schedule of Benefits.

Benefits

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Diagnostic Services		
Intraoral Bitewing Radiographs (Bitewing X-ray) Limited to 2 series of films per 12 months.	100% Not subject to the Dental Services Deductible.	50%
Panorex Radiographs (Full Jaw X-ray) or Complete Series Radiographs (Full Set of X-rays) Limited to 1 time per 36 months.	50%	50%
Periodic Oral Evaluation (Checkup Exam) Limited to 2 times per 12 months. Covered as a separate benefit only if no other service was done during the visit other than X-rays.	100% Not subject to the Dental Services Deductible.	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Preventive Services		
Dental Prophylaxis (Cleanings) Limited to 2 times per 12 months.	100% Not subject to the Dental Services Deductible.	50%
Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.	100% Not subject to the Dental Services Deductible.	50%
Sealants (Protective Coating) Limited to once per first or second permanent molar every 36 months.	100% Not subject to the Dental Services Deductible.	50%
Space Maintainers (Spacers) Benefit includes all adjustments within 6 months of installation.	100% Not subject to the Dental Services Deductible.	50%
Minor Restorative Services, Endodontics, Periodontics and Oral Surgery		
Amalgam Restorations (Silver Fillings) Multiple restorations on one surface will be treated as a single filling.	50%	50%
Composite Resin Restorations (Tooth Colored Fillings) For anterior (front) teeth only.	50%	50%
Endodontics (Root Canal Therapy)	50%	50%
Periodontal Surgery (Gum Surgery) Limited to 1 quadrant or site per 36 months per surgical area.	50%	50%
Scaling and Root Planing (Deep Cleanings) Limited to 1 time per quadrant per 24 months.	50%	50%
Periodontal Maintenance (Gum Maintenance) Limited to 4 times per 12 month period in conjunction with dental prophylaxis following active and adjunctive periodontal therapy, exclusive of gross debridement.	50%	50%
Simple Extractions (Simple tooth removal) Limited to 1 time per tooth per lifetime.	50%	50%
Oral Surgery, including Surgical Extraction	50%	50%
Adjunctive Services		
General Services (including Dental Emergency treatment) Covered as a separate benefit only if no other service was done during the visit other than X-rays. General anesthesia is covered when clinically necessary. Occlusal guards limited to 1 guard every 12 months.	50%	50%
Major Restorative Services Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment is limited to 1 time per 60 months from initial or supplemental placement.		
Inlays/Onlays/Crowns (Partial to Full Crowns) Limited to 1 time per tooth per 60 months. Covered only when silver fillings cannot restore the tooth.	50%	50%
Fixed Prosthetics (Bridges) Limited to 1 time per tooth per 60 months. Covered only when a filling cannot restore the tooth.	50%	50%
Removable Prosthetics (Full or partial dentures) Limited to 1 per 60 months. No additional allowances for precision or semi-precision attachments.	50%	50%

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
Relining and Rebasings Dentures Limited to relining/rebasings performed more than 6 months after the initial insertion. Limited to 1 time per 12 months.	50%	50%
Repairs or Adjustments to Full Dentures, Partial Dentures, Bridges, or Crowns Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per 6 months.	50%	50%
Implants		
Implant Placement Limited to 1 time per 60 months.	50%	50%
Implant Supported Prosthetics Limited to 1 time per 60 months.	50%	50%
Implant Maintenance Procedures Includes removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis. Limited to 1 time per 60 months.	50%	50%
Repair Implant Supported Prosthesis by Report Limited to 1 time per 60 months.	50%	50%
Abutment Supported Crown (Titanium) or Retainer Crown for FPD - Titanium Limited to 1 time per 60 months.	50%	50%
Repair Implant Abutment by Support Limited to 1 time per 60 months.	50%	50%
Radiographic/Surgical Implant Index by Report Limited to 1 time per 60 months.	50%	50%
MEDICALLY NECESSARY ORTHODONTICS		
Benefits for comprehensive orthodontic treatment are approved by the Company, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the Company's dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies. All orthodontic treatment must be prior authorized.		
Orthodontic Services Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.	50%	50%

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided under Section 2: Benefits for Covered Dental Services, benefits are not provided for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in Section 2: Benefits for Covered Dental Services.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Condition, when the primary purpose is to improve physiological functioning of the involved part of the body.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.

8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Conditions of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including surgery related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Insured Person's Effective Date of coverage.
16. Dental Services otherwise covered under the policy, but rendered after the date individual coverage under the policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the policy terminates.
17. Services rendered by a provider with the same legal residence as the Insured Person or who is a member of the Insured Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required for a Dental Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the policy.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, the Insured Person will be required to pay all billed charges directly to the Dental Provider. The Insured Person may then seek reimbursement from the Company. The Insured Person must provide the Company with all of the information identified below.

Reimbursement for Dental Services

The Insured Person is responsible for sending a request for reimbursement to the Company, on a form provided by or satisfactory to the Company.

Claim Forms

It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Insured Person's name and address.
- Insured Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the CPT or ADA codes or description of each charge.
- The date the dental disease began.

- A statement indicating that the Insured Person is or is not enrolled for coverage under any other health or dental insurance plan or program. If enrolled for other coverage the Insured Person must include the name of the other carrier(s).

To file a claim, submit the above information to the Company at the following address:

UnitedHealthcare Dental
 Attn: Claims Unit
 P.O. Box 30567
 Salt Lake City, UT 84130-0567

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

If the Insured Person would like to use a claim form, the Insured Person can request one be mailed by calling Customer Service at 1-877-816-3596. This number is also listed on the Insured's Dental ID Card.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Dental Service – a Dental Service or Dental Procedure for which benefits are provided under this endorsement.

Dental Emergency - a dental condition or symptom resulting from dental disease which arises suddenly and, in the judgment of a reasonable person, requires immediate care and treatment, and such treatment is sought or received within 24 hours of onset.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to the Insured Person while the policy is in effect, provided such care or treatment is recognized by the Company as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are the Company's contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are the Usual and Customary Fees, as defined below.

Experimental, Investigational, or Unproven Service - medical, dental, surgical, diagnostic, or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Company makes a determination regarding coverage in a particular case, is determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Subject to review and approval by any institutional review board for the proposed use; or
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- Not determined through prevailing peer-reviewed professional literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed.

Foreign Services - services provided outside the U.S. and U.S. Territories.

Necessary - Dental Services and supplies which are determined by the Company through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:

- Necessary to meet the basic dental needs of the Insured Person.
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by the Company.
- Consistent with the diagnosis of the condition.
- Required for reasons other than the convenience of the Insured Person or his or her Dental Provider.
- Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - ◆ For treating a life threatening dental disease or condition.
 - ◆ Provided in a clinically controlled research setting.
 - ◆ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this endorsement. The definition of Necessary used in this endorsement relates only to benefits under this endorsement and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Network - a group of Dental Providers who are subject to a participation agreement in effect with the Company, directly or through another entity, to provide Dental Services to Insured Persons. The participation status of providers will change from time to time.

Network Benefits - benefits available for Covered Dental Services when provided by a Dental Provider who is a Network Dentist.

Non-Network Benefits - benefits available for Covered Dental Services obtained from Non-Network Dentists.

Usual and Customary Fee - Usual and Customary Fees are calculated by the Company based on available data resources of competitive fees in that geographic area.

Usual and Customary Fees must not exceed the fees that the provider would charge any similarly situated payor for the same services.

Usual and Customary Fees are determined solely in accordance with the Company's reimbursement policy guidelines. The Company's reimbursement policy guidelines are developed by the Company, in its discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (publication of the American Dental Association).
- As reported by generally recognized professionals or publications.
- As utilized for Medicare.
- As determined by medical or dental staff and outside medical or dental consultants.
- Pursuant to other appropriate source or determination that the Company accepts.

Pediatric Vision Care Services Benefits

Benefits are provided for Vision Care Services for Insured Persons under the age of 19. Benefits terminate on the earlier of: 1) last day of the month the Insured Person reaches the age of 19; or 2) the date the Insured Person's coverage under the policy terminates.

Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, the Insured Person may call the provider locator service at 1-800-839-3242. The Insured Person may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When Vision Care Services are obtained from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges at the time of service. The Insured Person may then seek reimbursement from the Company as described under Section 3: Claims for Vision Care Services. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, the Insured Person will be required to pay any Copayments at the time of service.

Network Benefits

Benefits for Vision Care Services are determined based on the negotiated contract fee between the Company and the Vision Care Provider. The Company's negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Non-Network Benefits

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Policy Deductible

Benefits for pediatric Vision Care Services are not subject to any policy Deductible stated in the policy Schedule of Benefits. Any amount the Insured Person pays in Copayments for Vision Care Services does not apply to the policy Deductible stated in the policy Schedule of Benefits.

Benefit Description

When benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated. Benefit limits are calculated on a Policy Year basis unless otherwise specifically stated.

Benefits are provided for the Vision Care Services described below, subject to Frequency of Service limits and Copayments and Coinsurance stated under each Vision Care Service in the Schedule of Benefits below.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which the Insured Person resides, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well the Insured sees at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses - Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations.

Eyeglass Frames - A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

Contact Lenses - Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

The Insured Person is eligible to select only one of either eyeglasses (Eyeglass Lenses and/or Eyeglass Frames) or Contact Lenses. If the Insured Person selects more than one of these Vision Care Services, the Company will pay benefits for only one Vision Care Service.

Necessary Contact Lenses - Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by the Company. Contact lenses are necessary if the Insured Person has any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.
- Pathological myopia.
- Aniseikonia.
- Aniridia.
- Post-traumatic disorders.

Low Vision - Benefits are available to an Insured Person who has severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by the Company.

This benefit includes:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Routine Vision Examination or Refraction only in lieu of a complete exam.	Once per year.	100% after a Copayment of \$20.	50% of the billed charge.
Eyeglass Lenses	Once per year.		
• Single Vision		100% after a Copayment of \$40.	50% of the billed charge.
• Bifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Trifocal		100% after a Copayment of \$40.	50% of the billed charge.
• Lenticular		100% after a Copayment of \$40.	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
Lens Extras	Once per year.		
• Polycarbonate lenses		100%	100% of the billed charge.
• Standard scratch-resistant coating		100%	100% of the billed charge.
Eyeglass Frames	Once per year.		
• Eyeglass frames with a retail cost up to \$130.		100%	50% of the billed charge.
• Eyeglass frames with a retail cost of \$130 - 160.		100% after a Copayment of \$15.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$160 - 200.		100% after a Copayment of \$30.	50% of the billed charge.
• Eyeglass frames with a retail cost of \$200 - 250.		100% after a Copayment of \$50.	50% of the billed charge.
• Eyeglass frames with a retail cost greater than \$250.		60%	50% of the billed charge.
Contact Lenses	Limited to a 12 month supply.		
• Covered Contact Lens Selection		100% after a Copayment of \$40.	50% of the billed charge.
• Necessary Contact Lenses		100% after a Copayment of \$40.	50% of the billed charge.
Low Vision Services Note that benefits for these services will be paid as reimbursements. When obtaining these Vision Services, the Insured will be required to pay all billed charges at the time of service. The Insured may then obtain reimbursement from the Company. Reimbursement will be limited to the amounts stated.	Once every 24 months.		
• Low Vision Testing		100% of the billed charge.	75% of the billed charge.
• Low Vision Therapy		100% of the billed charge.	75% of the billed charge.

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided under Section 1: Benefits for Pediatric Vision Care Services, benefits are not provided for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which benefits are available as stated in the policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in Section 1: Benefits for Vision Care Services.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, the Insured Person will be required to pay all billed charges directly to the Vision Care Provider. The Insured Person may then seek reimbursement from the Company.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Reimbursement for Low Vision Services

To file a claim for reimbursement for Low Vision Services, the Insured Person must provide all of the following information at the address specified below:

- Insured Person's itemized receipts.
- Insured Person's name.
- Insured Person's identification number.
- Insured Person's date of birth.

Submit the above information to the Company:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Submit claims for payment within 90 days after the date of service. If the Insured doesn't provide this information within one year of the date of service, benefits for that service may be denied at our discretion. This time limit does not apply if the Insured is legally incapacitated.

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to the policy DEFINITIONS:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Copayment.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by the Company who provides Vision Care Services for which benefits are available under the policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in Section 1: Benefits for Pediatric Vision Care Services.

Notice of Appeal Rights

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Adverse Determination.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 800-767-0700 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

Expedited Internal Appeal

For Emergent Health Care Services or life threatening situations, an Insured Person may submit a request, either orally or in writing, for an Expedited Internal Appeal.

Emergent Health Care Services are those resources provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.

To request an Expedited Internal Appeal, please contact Claims Appeals at 888-315-0447. The written request for an Expedited Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **StudentResources**, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

Upon completion of the Internal Appeal, if the Adverse Determination is upheld, the Company shall provide for an external appeal by an unrelated and objective external appeals agency, designated by the Director of Insurance.

To initiate an external appeal, the Insured Person or Authorized Representative shall file written request for such appeal with the Company. Such request shall include a check payable to the external appeals agency for one-half (1/2) the pre-determined fee. The pre-determined fee is based upon which external review agency performs the review.

1. The predetermined fee includes all administrative costs and the cost of the reviewing physician or dentist.
2. An external appeal must be filed within four (4) months of receiving notice that the internal appeal has been denied.
3. If the decision of the Company is overturned by the external appeals agency, the appealing party shall be reimbursed by the Company within sixty (60) days of the notice of the overturn for their share of the appeal fee paid as defined herein.

Where to Send External Review Requests

All External Review requests shall be submitted to Claims Appeals at the following address:

Claims Appeals
UnitedHealthcare **StudentResources**
PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, please contact:

Rhode Island Department of Health
Office of Managed Care Regulation
3 Capitol Hill, Room 410
Providence, RI 02908
Telephone: (401) 222-6015
E-mail: DOH.ManagedCare@health.ri.gov

AND

Rhode Island Insurance Resource, Education, and Assistance Consumer Helpline (RIREACH)
1210 Pontiac Avenue
Cranston, RI 02920
Telephone: (855) 747-3224 (855-RIREACH)
Web site: www.rireach.org
E-mail: rireach@ripin.org

The Plan is Underwritten by:
UNITEDHEALTHCARE INSURANCE COMPANY

Administrative Office:
UnitedHealthcare **Student**Resources
P.O. Box 809025
Dallas, Texas 75380-9025
800-767-0700
972-233-8200

Sales/Marketing Services:
UnitedHealthcare **Student**Resources
805 Executive Center Drive West, Suite 220
St. Petersburg, FL 33702
727-563-3400
800-237-0903
E-mail: info@uhcsr.com

Please keep this Brochure as a general summary of the insurance. The Master Policy on file at the College contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Brochure. The Master Policy is the contract and will govern and control the payment of benefits.

This Brochure is based on Policy #2016-608-1.

